Washington State Department of Health

Send completed forms to DOH Communicable Disease Epidemiology
Fax: 206-361-2930

Hepatitis B, acute

County

LHJ Use **ID** _____
☐ **Reported to DOH** **Date** ___/___/___
LHJ Classification ☐ **Confirmed**
☐ **Probable**
By: ☐ **Lab** ☐ **Clinical**
☐ **Other:** _____
Outbreak # (LHJ) _____ **(DOH)** _____

DOH Use ***ID*** _____
Date Received ___/___/___
DOH Classification
☐ ***Confirmed***
☐ ***Probable***
☐ ***No count; reason:***

REPORT SOURCE

Initial report date ___/___/___
Reporter (check all that apply)
☐ Lab ☐ Hospital ☐ HCP
☐ Public health agency ☐ Other
OK to talk to case? ☐ Yes ☐ No ☐ Don't know

Reporter name _____
Reporter phone _____
Primary HCP name _____
Primary HCP phone _____

PATIENT INFORMATION

Name (last, first) _____
Address _____ ☐ Homeless
City/State/Zip _____
Phone(s)/Email _____
Alt. contact ☐ Parent/guardian ☐ Spouse ☐ Other Phone: _____
Occupation/grade _____
Employer/worksite _____ School/child care name _____

Birth date ___/___/___ Age _____
Gender ☐ F ☐ M ☐ Other ☐ Unk
Ethnicity ☐ Hispanic or Latino
☐ Not Hispanic or Latino
Race (check all that apply)
☐ Amer Ind/AK Native ☐ Asian
☐ Native HI/other PI ☐ Black/Afr Amer
☐ White ☐ Other

CLINICAL INFORMATION

Onset date: ___/___/___ ☐ Derived Diagnosis date: ___/___/___ Illness duration: _____days

Signs and Symptoms

Y	N	DK	NA	
☐	☐	☐	☐	**Discrete onset of symptoms**
☐	☐	☐	☐	Diarrhea Maximum # of stools in 24 hours: ____
☐	☐	☐	☐	**Pale stool, dark urine (jaundice)** Onset date ___/___/___
☐	☐	☐	☐	**Abdominal cramps or pain**
☐	☐	☐	☐	**Nausea**
☐	☐	☐	☐	**Vomiting**
☐	☐	☐	☐	**Loss of appetite (anorexia)**
☐	☐	☐	☐	**Fatigue**

Predisposing Conditions

Y	N	DK	NA	
☐	☐	☐	☐	Pregnant Estimated delivery date ___/___/___ OB name, address, phone: _____ _____
☐	☐	☐	☐	History of viral hepatitis, specify type:

Hepatitis A ☐**Y** ☐**N** ☐**DK** ☐**NA**
Hepatitis B ☐**Y** ☐**N** ☐**DK** ☐**NA**
Chronic hepatitis B infection (HBsAg positive > 6 months ago) ☐**Y** ☐**N** ☐**DK** ☐**NA**
Hepatitis C ☐**Y** ☐**N** ☐**DK** ☐**NA**
Hepatitis D ☐**Y** ☐**N** ☐**DK** ☐**NA**
Other viral hepatitis infection ☐**Y** ☐**N** ☐**DK** ☐**NA**
Hepatitis of unknown type ☐**Y** ☐**N** ☐**DK** ☐**NA**

Clinical Findings

Y	N	DK	NA	
☐	☐	☐	☐	Complications, specify: _____

Hospitalization

Y	N	DK	NA	
☐	☐	☐	☐	Hospitalized for this illness

Hospital name _____
Admit date ___/___/___ Discharge date ___/___/___

Y	N	DK	NA	
☐	☐	☐	☐	Died from illness Death date ___/___/___
☐	☐	☐	☐	**Autopsy**

Vaccinations

Y	N	DK	NA	
☐	☐	☐	☐	Received any doses of hepatitis B vaccine Year of last HBV vaccine dose: _____ Number of doses of HBV vaccine in past: _____ If 3 hepatitis B vaccine doses, titer of HBV antibody test 1-6 mo's from third dose: _____

Laboratory

Collection date ___/___/___

Y	N	DK	NA	
☐	☐	☐	☐	**IgM to core antigen (anti-HBc) positive**
☐	☐	☐	☐	**HBsAg positive**
☐	☐	☐	☐	**Serum aminotransferase [SGOT (AST), SGPT (ALT)] elevated above normal**

Case defining variables are in **bold.** Answers are: Yes, No, Unknown to case, Not asked /Not answered

INFECTION TIMELINE

Enter jaundice onset date in heavy box. Count forward and backward to figure probable exposure and contagious periods

	Exposure period		onset	***Contagious period****
Days from onset:	-180	-45		many weeks prior — weeks to years after onset
Calendar dates:				

** Lifelong if chronic infection*

EXPOSURE (Refer to dates above)

Y	N	DK	NA	
☐	☐	☐	☐	Travel out of the state, out of the country, or outside of usual routine Out of: ☐ County ☐ State ☐ Country Destinations/Dates: _____
☐	☐	☐	☐	Case knows anyone with similar symptoms
☐	☐	☐	☐	Contact with confirmed or suspect HBV case ☐ Household ☐ Sexual ☐ Needle use ☐ Other: _____
☐	☐	☐	☐	Birth mother-history of viral hepatitis
☐	☐	☐	☐	Birth mother-HbsAg positive
☐	☐	☐	☐	Birth mother has history of hepatitis C infection
☐	☐	☐	☐	Congregate living Type: ☐ Barracks ☐ Corrections ☐ Long term care ☐ Dormitory ☐ Boarding school ☐ Camp ☐ Shelter ☐ Other: _____
☐	☐	☐	☐	Hospitalized during exposure period
☐	☐	☐	☐	Any medical or dental procedure:
☐	☐	☐	☐	Hemodialysis
☐	☐	☐	☐	IV or injection as outpatient
☐	☐	☐	☐	Blood transfusion or blood products (e.g. IG, factor concentrates) Date of receipt: __/__/__
☐	☐	☐	☐	Organ or tissue transplant recipient, date:__/__/__
☐	☐	☐	☐	Dental work or oral surgery
☐	☐	☐	☐	Non-oral surgery type: _____
☐	☐	☐	☐	Acupuncture
☐	☐	☐	☐	Employed in job with potential for exposure to human blood or body fluids, Job type: ☐ Public Safety ☐ Health care (e.g. medical, dental, laundry) ☐ Tattoo or piercing ☐ Other Frequency of direct blood or body fluid exposure ☐ Frequent (several times weekly) ☐ Infrequent ☐ Unknown

Y	N	DK	NA	
☐	☐	☐	☐	Accidental parenteral exposure to blood
☐	☐	☐	☐	Accidental non-intact skin or mucous membrane exposure to blood
☐	☐	☐	☐	Body piercing ☐ Home ☐ Commercial ☐ Prison ☐ Unk
☐	☐	☐	☐	Tattooing ☐ Home ☐ Commercial ☐ Prison ☐ Unk
☐	☐	☐	☐	Other body modification (e.g. scarification)
☐	☐	☐	☐	Shared razor, toothbrushes or nail care items
☐	☐	☐	☐	Non-injection street drug use Shared equipment non-IDU ☐**Y** ☐**N** ☐**DK** ☐**NA**
☐	☐	☐	☐	Injection street drug use, type: _____
☐	☐	☐	☐	Shared injection equipment
☐	☐	☐	☐	Born outside US
☐	☐	☐	☐	Household or sexual contact from endemic country, specify country: _____
☐	☐	☐	☐	Any type of sexual contact with others # lifetime total sexual partners: _____ # female sexual partners: _____ # male sexual partners: _____
☐	☐	☐	☐	Ever diagnosed with an STD Treated for STD ☐**Y** ☐**N** ☐**DK** ☐**NA** Year of most recent treatment: _____
☐	☐	☐	☐	Physical assault on exposed person involving blood or semen
☐	☐	☐	☐	Other blood or body fluid exposure Other exposure source: _____

☐ **Patient could not be interviewed**
☐ **No risk factors or exposures could be identified**

Most likely exposure/site: _____ **Site name/address:** _____
Where did exposure probably occur? ☐ In WA (County: _____) ☐ US but not WA ☐ Not in US ☐ Unk

PUBLIC HEALTH ISSUES

Y	N	DK	NA	
☐	☐	☐	☐	Employed as health care worker, if yes: Employed in a job with human blood exposure: ☐ Several times a week ☐ Infrequently ☐ No ☐ Unknown
☐	☐	☐	☐	Patient in a dialysis or kidney transplant unit
☐	☐	☐	☐	Did case donate blood products, organs or tissue (including ova or semen) in the 30 days before symptom onset Date: ___/___/___ Agency and location: _____ Specify type of donation: _____
☐	☐	☐	☐	Outbreak related

PUBLIC HEALTH ACTIONS

☐ Notify blood or tissue bank
☐ Prophylaxis of appropriate contacts recommended
Number recommended prophylaxis: _____
Number receiving prophylaxis: _____
Number completing prophylaxis: _____
☐ Counseled patient regarding retesting in 3-6 months
☐ Health care worker performing invasive procedures
☐ Retesting during pregnancy recommended
☐ Mom counseled about pregnancy risks
☐ Other, specify: _____

Investigator _____ **Phone/email:** _____ **Investigation complete date** ___/___/___

Local health jurisdiction _____

Hepatitis B, acute: case defining variables are in **bold.** Answers are: Yes, No, Unknown to case, Not asked /Not answered